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UNITED STATES PATENT APPLICATION

FOR

**METHOD AND APPARATUS FOR MODIFYING VISUAL ACUITY BY MOVING  
A FOCAL POINT OF ENERGY WITHIN A CORNEA**

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## REFERENCE TO CROSS-RELATED APPLICATIONS

This application is a continuation-in-part of Application No. 09/239,060, filed on January 26, 1999, pending, which is a continuation of Application No.

5 08/957,911, filed on October 27, 1997, pending, which is a continuation-in-part of Application No. 08/287,657, U.S. Patent No. 5,749,871, which is a continuation-in-part of Application No. 08/171,255, filed on December 20, 1993, abandoned, which is a continuation-in-part of Application  
10 No. 08/111,296, filed on August 23, 1993, abandoned.

## BACKGROUND OF THE INVENTION

### 1. Field of the Invention

The present invention relates to a method and system for varying a refractive characteristic of a cornea.

### 15 2. Background Information

Techniques for correcting vision have included reshaping the cornea of the eye. For example, myopic conditions can be corrected by cutting a number of small incisions in the corneal membrane. The incisions allow the  
20 corneal membrane to relax and increase the radius of the

cornea. The incisions are typically created with either a laser or a precision knife. The procedure for creating incisions to correct myopic defects is commonly referred to as radial keratotomy and is well known in the art.

5 Present radial keratotomy techniques generally make incisions that penetrate approximately 95% of the cornea. Penetrating the cornea to such a depth increases the risk of puncturing the Descemets membrane and the endothelium layer, and creating permanent damage to the eye.

10 Additionally, light entering the cornea at the incision sight is refracted by the incision scar and produces a glaring effect in the visual field. The glare effect of the scar produces impaired night vision for the patient. It would be desirable to have a procedure for correcting

15 myopia that does not require a 95% penetration of the cornea.

The techniques of radial keratotomy are only effective in correcting myopia. Radial keratotomy cannot be used to correct an eye condition such as hyperopia. Additionally,

20 keratotomy has limited use in reducing or correcting an astigmatism. The cornea of a patient with hyperopia is

relatively flat (large spherical radius). A flat cornea creates a lens system which does not correctly focus the viewed image onto the retina of the eye. Hyperopia can be corrected by reshaping the eye to decrease the spherical  
5 radius of the cornea. It has been found that hyperopia can be corrected by heating and denaturing local regions of the cornea. The denatured tissue contracts and changes the shape of the cornea and corrects the optical characteristics of the eye. The procedure of heating the  
10 corneal membrane to correct a patient's vision is commonly referred to as thermokeratoplasty.

U.S. Patent No. 4,461,294 issued to Baron; U.S. Patent No. 4,976,709 issued to Sand and PCT Publication WO  
90/12618, all disclose thermokeratoplasty techniques which  
15 utilize a laser to heat the cornea. The energy of the laser generates localized heat within the corneal stroma through photonic absorption. The heated areas of the stroma then shrink to change the shape of the eye.

Although effective in reshaping the eye, the laser  
20 based systems of the Baron, Sand and PCT references are relatively expensive to produce, have a non-uniform thermal

conduction profile, are not self limiting, are susceptible to providing too much heat to the eye, may induce astigmatism and produce excessive adjacent tissue damage, and require long term stabilization of the eye. Expensive laser systems increase the cost of the procedure and are economically impractical to gain widespread market acceptance and use. Additionally, laser thermokeratoplastic techniques non-uniformly shrink the stroma without shrinking the Bowmans layer. Shrinking the stroma without a corresponding shrinkage of the Bowmans layer, creates a mechanical strain in the cornea. The mechanical strain may produce an undesirable reshaping of the cornea and probable regression of the visual acuity correction as the corneal lesion heals. Laser techniques may also perforate Bowmans layer and leave a leucoma within the visual field of the eye.

U.S. Patent Nos. 4,326,529 and 4,381,007 issued to Doss et al, disclose electrodes that are used to heat large areas of the cornea to correct for myopia. The electrode is located within a housing that spaces the tip of the electrode from the surface of the eye. An isotropic saline

solution is irrigated through the electrode and aspirated through a channel formed between the outer surface of the electrode and the inner surface of the sleeve. The saline solution provides an electrically conductive medium between the electrode and the corneal membrane. The current from the electrode heats the outer layers of the cornea.

Heating the outer eye tissue causes the cornea to shrink into a new radial shape. The saline solution also functions as a coolant which cools the outer epithelium layer.

The saline solution of the Doss device spreads the current of the electrode over a relatively large area of the cornea. Consequently, thermokeratoplasty techniques using the Doss device are limited to reshaped corneas with relatively large and undesirable denatured areas within the visual axis of the eye. The electrode device of the Doss system is also relatively complex and cumbersome to use.

"A Technique for the Selective Heating of Corneal Stroma" Doss et al., Contact & Intraocular Lens Medical Jrl., Vol. 6, No. 1, pp. 13-17, Jan-Mar., 1980, discusses a procedure wherein the circulating saline electrode (CSE) of

the Doss patent was used to heat a pig cornea. The electrode provided 30 volts r.m.s. of power for 4 seconds. The results showed that the stroma was heated to 70°C and the Bowman's membrane was heated 45°C, a temperature below the 50-55°C required to shrink the cornea without regression.

"The Need For Prompt Prospective Investigation"

McDonnell, Refractive & Corneal Surgery, Vol. 5, Jan./Feb., 1989 discusses the merits of corneal reshaping by thermokeratoplasty techniques. The article discusses a procedure wherein a stromal collagen was heated by radio frequency waves to correct for a keratoconus condition. As the article reports, the patient had an initial profound flattening of the eye followed by significant regression within weeks of the procedure.

"Regression of Effect Following Radial

Thermokeratoplasty in Humans" Feldman et al., Refractive and Corneal Surgery, Vol. 5, Sept./Oct., 1989, discusses another thermokeratoplasty technique for correcting hyperopia. Feldman inserted a probe into four different locations of the cornea. The probe was heated to 600°C and

was inserted into the cornea for 0.3 seconds. Like the procedure discussed in the McDonnell article, the Feldman technique initially reduced hyperopia, but the patients had a significant regression within 9 months of the procedure.

5 To date, there have been no published findings of a thermokeratoplasty technique that will predictably reshape and correct the vision of a cornea without a significant regression of the corneal correction.

10 It would therefore be desirable to provide a thermokeratoplasty technique which can predictably reshape and correct the vision of an eye without a significant regression of the visual acuity correction.

15 It would be desirable to know the electrical contact between an electrode and the cornea before conducting an electro-thermokeratoplasty procedure. A cornea that is too dry may create a high electrical impedance that produces a relatively large amount of localized heating in the tissue. A cornea that is too wet may dissipate the current so that the corneal tissue is not sufficiently denatured. It would  
20 be desirable to provide a power supply and technique that

can test the condition of the eye to determine if there is an acceptable electrical path.

Varying the refractive characteristics of a cornea with an electro-thermokeratoplasty procedure typically results in a denatured volume of corneal tissue that tapers inward from the outer surface of the stroma. The resulting tapered denatured volume may allow a regression in the correction of the cornea. It would be desirable to provide a technique and system that can denature corneal tissue in a volume that has a relatively uniform cross-sectional area.

BRIEF SUMMARY OF THE INVENTION

One embodiment of the present invention is a medical system that can direct energy onto a focal point located within a cornea. The system can vary the focal point of  
5 the energy through the cornea.

## BRIEF DESCRIPTION OF THE DRAWINGS

Figure 1 is a perspective view of a thermokeratoplasty electrode system of the present invention;

Figure 1a is a graph showing a waveform that is  
5 provided to the probe of the system;

Figure 1b is a graph showing the amount of typical vision correction regression over time;

Figure 1c is a representation of a nominal thermal profile within the cornea produced by the electrode system  
10 of the present invention;

Figure 2 is a top view of an electrode probe of the system;

Figure 3 is a side view of the probe in Fig. 2;

Figure 4 is an enlarged view of the probe tip;

15 Figure 5 is a side view showing the probe being used to treat an area of the corneal membrane;

Figure 6 is a top view showing a pattern of denatured areas of the cornea;

20 Figure 7 is a perspective view of an alternate embodiment of the probe;

Figures 8a-b show a method for performing a procedure of the present invention;

Figure 9 shows a pattern of incisions and denatured areas to correct for a myopic condition;

5 Figure 10 shows another pattern of incisions and denatured areas to correct for hyperopic conditions;

Figure 11 shows a preferred embodiment of the present invention;

Figure 11a is an enlarged view of the tip of Figure 11;

10 Figure 12 is a perspective view of a probe with the return electrode as a lid speculum that maintains the eyelid in an open position;

Figure 13 is a side view of an alternate probe tip embodiment;

15 Figure 14 is a side view of an alternate probe tip embodiment;

Figure 15 is a side view of an alternate probe tip embodiment;

20 Figure 16 is a side view of an alternate probe tip embodiment;

Figure 17 is a side view of an alternate probe tip embodiment;

Figure 18 is a side view of an alternate probe embodiment;

5        Figure 19 is a schematic of a circuit which limits the use of a probe beyond a predetermined useful life;

Figure 20 is a side view of an alternate probe tip design;

10       Figure 21 is an enlarged cross-sectional view of the probe tip;

Figure 22 is an enlarged view of the probe tip inserted into a cornea;

Figure 23 is a side view of an alternate embodiment of an electrode;

15       Figure 24 is a side view of an alternate embodiment of an electrode;

Figure 25 is a side view of an alternate embodiment of an electrode;

20       Figure 26 is a schematic of an embodiment of a power supply;

Figure 27 is a flowchart showing an operation of the power supply;

Figures 28a-j are end views of alternate embodiments of an electrode;

5 Figure 29 is a cross-sectional view of an alternate embodiment of a probe assembly;

Figure 30 is a cross-sectional view showing a probe holder for the probe of the assembly shown in Fig. 29;

10 Figure 31 is a cross-sectional view of an alternate embodiment of a probe assembly;

Figure 32 is an enlarged cross-sectional view of a probe of the assembly shown in Fig. 30;

Figure 33 is a cross-sectional view of an alternate embodiment of a probe assembly;

15 Figure 34 is a side view showing an alternate embodiment of a handle for a probe assembly;

Figure 35 is an illustration showing an embodiment of a medical system of the present invention;

20 Figure 36 is an illustration showing a cornea denatured with the system shown in Figure 35;

Figure 37 is an illustration of an alternate embodiment of the medical system shown in Fig. 35;

Figure 38 is an illustration of an alternate embodiment of the medical system shown in Fig. 35;

5 Figure 39 is an illustration of an alternate embodiment of the medical system shown in Fig. 35;

Figure 40 is an illustration of an alternate embodiment of the medical system shown in Fig. 35.

DETAILED DESCRIPTION OF THE PREFERRED EMBODIMENT

Referring to the drawings more particularly by  
reference numbers, Figure 1 shows a thermokeratoplastic  
electrode system 10 of the present invention. The system  
10 includes an electrode probe 12 coupled to a power supply  
unit 14. The power supply unit 14 contains a power supply  
which can deliver power to the probe 12. The probe 12 has  
a hand piece 16 and wires 18 that couple the probe  
electrodes to a connector 20 that plugs into a mating  
receptacle 22 located on the front panel 24 of the power  
unit. The hand piece 16 may be constructed from a non-  
conductive material and is approximately 0.5 inches in  
diameter and 5 inches long.

The power supply 14 provides a predetermined amount of  
energy, through a controlled application of power for a  
predetermined time duration. The power supply 14 may have  
manual controls that allow the user to select treatment  
parameters such as the power and time duration. The power  
supply 14 can also be constructed to provide an automated  
operation. The supply 14 may have monitors and feedback  
systems for measuring tissue impedance, tissue temperature

and other parameters, and adjust the output power of the supply to accomplish the desired results. The unit may also have a display that indicates the number of remaining uses available for the probe 12.

5 In the preferred embodiment, the power supply provides a constant current source and voltage limiting to prevent arcing. To protect the patient from overvoltage or overpower, the power unit 14 may have an upper voltage limit and/or upper power limit which terminates power to  
10 the probe when the output voltage or power of the unit exceeds a predetermined value. The power unit 14 may also contain monitor and alarm circuits which monitor the resistance or impedance of the load and provide an alarm when the resistance/impedance value exceeds and/or falls  
15 below predefined limits. The alarm may provide either an audio and/or visual indication to the user that the resistance/impedance value has exceeded the outer predefined limits. Additionally, the unit may contain a ground fault indicator, and/or a tissue temperature  
20 monitor. The front panel of the power unit typically contains meters and displays that provide an indication of

the power, frequency, etc., of the power delivered to the probe.

The power unit 14 may deliver a power output in a frequency range of 5 KHz- 50 MHz. In the preferred embodiment, power is provided to the probe at a frequency in the range of 500 KHz. The unit 14 is designed so that the power supplied to the probe 12 does not exceed 1.2 watts (W). The time duration of each application of power to a particular corneal location is typically between 0.1-1.0 seconds. The unit 14 is preferably set to deliver approximately .75 W of power for 0.75 seconds. Figure 1a shows a typical voltage waveform that is applied by the unit 14. Each pulse of energy delivered by the unit 14 is a highly damped signal, typically having a crest factor (peak voltage/RMS voltage) greater than 10:1. Each power dissipation is provided at a repetitive rate. The repetitive rate may range between 4-12 KHz and is preferably set at 8 KHz.

The system has a switch which controls the application of power to the probe 12. The power unit 14 also contains a timer circuit which allows power to be supplied to the

probe 12 for a precise predetermined time interval. The timer may be a Dose timer or other similar conventional circuitry which terminates power to the probe after a predetermined time interval. The unit may also allow the user to apply power until the switch is released. As one embodiment, the power supply may be a unit sold by Birtcher Medical Co. under the trademark HYFRECTOR PLUS, Model 7-797 which is modified to have voltage, waveform, time durations and power limits to comply with the above cited specifications.

The power unit 14 may have a control member 26 to allow the user to select between a "uni-polar" or a "bi-polar" operation. The power supply 14 may be constructed to provide a single range of numerical settings, whereupon the appropriate output power, time duration and repetition rate are determined by the hardware and software of the unit. The front panel of the power unit may also have control members (not shown) that allow the surgeon to vary the power, frequency, timer interval, etc. of the unit. The return electrode (not shown) for a uni-polar probe may be coupled to the power unit through a connector located on

the unit. The return electrode is preferably a cylindrical bar that is held by the patient, or an eye fixation electrode.

It has been found that at higher diopters, effective results can be obtained by providing two different applications at the same location. Listed below in Table I are the power settings (peak power) and time duration settings for different diopter corrections (-d), wherein the locations (Loc) are the number of denatured areas in the cornea and dots/Loc is the number of power applications per location.

TABLE I				
-d	DOTS/LOC	LOC	PWR (W)	TIME (SEC )
1.5	1	8	0.66	.75
2.5	2	8	0.66	.75
3.5	2	8	0.83	.75
4.5	2	16	0.66	.75
6.0	2	16	0.83	.75

Using the parameters listed in Table I, the procedure of the present invention was performed on 36 different

patients suffering from some degree of hyperopia. A pattern of 8-16 denatured areas were created in the non-vision area of the eye. Patients who needed higher diopter corrections were treated with high applications of power.

5 Figure 1b shows the amount of regression in the vision correction of the eye. The eyes were initially overcorrected to compensate for the known regression in the procedure. As shown in Fig. 1b, the regression became stabilized after approximately 60 days and completely  
10 stabilized after 180 days. The error in overcorrection was within +/- 0.5 diopters.

Figure 1c shows nominal thermal profiles produced by the application of power to the cornea. As known to those skilled in the art, the cornea includes an epithelium  
15 layer, a Bowmans membrane, a stroma, a Descemets membrane and a endothelium layer. Without limiting the scope of the patent, the applicant provides the following discussion on the possible effects of the present method on the cornea of the eye. When power is first applied to the cornea the  
20 current flows through the center of the tissue immediately adjacent to the probe tip. The application of power causes

an internal ohmic heating of the cornea and a dehydration of the tissue. The dehydration of the tissue rapidly increases the impedance of the local heated area, wherein the current flows in an outward manner indicated by the arrows in Fig. 1c. The cycle of dehydration and outward current flow continues until the resistance from the tip to the outer rim of the corneal surface, and the full thermal profile, is significantly high to prevent further current flow of a magnitude to further cause denaturing of the corneal tissue. The direct contact of the probe with the cornea along the specific power/time settings of the power source creates a thermal profile that denatures both the Bowman's membrane and the stroma. The denaturing of both the Bowman's membrane and the stroma in a circular pattern creates a linked belt type contracted annular ring. This annular ring will create a steepening of the cornea and sharpen the focus of the images on the retina. To control and minimize the denatured area, the surface of the eye is kept dry by applying either a dry swab to the cornea or blowing dry air or nitrogen across the surface of the eye.

The design of the power source and the high electrical resistance of the denatured area provides a self limit on the amount of penetration and area of denaturing of the cornea. Once denatured, the cornea provides a high impedance to any subsequent application of power so that a relatively low amount of current flows through the denatured area. It has been found that the present procedure has a self limited denatured profile of approximately no greater than 75% of the depth of the stroma. This prevents the surgeon from denaturing the eye down to the Descemets membrane and endothelium layer of the cornea.

Fig. 1c shows nominal thermal profiles for diopter corrections of -1.5 d, -2.5-3.5 d and -4.0-6.0 d, respectively. In accordance with Table I, a -1.5 diopter correction creates a denatured diameter of approximately 1 mm and a stroma penetration of approximately 30%. A -2.5-3.5 d correction creates a denatured diameter of approximately 1.13 mm and a stroma penetration of approximately 50%. A -4.0-6.0 d correction creates a

denature diameter of approximately 1.25 mm and a stroma penetration of approximately 75%.

Figures 2-5 show an embodiment of the probe 12. The probe 12 has a first electrode 30 and a second electrode 32. Although two electrodes are described and shown, it is to be understood that the probe may have either both electrodes (bipolar) or just the first electrode (unipolar). If a unipolar probe is used, a return electrode (indifferent electrode) is typically attached to, or held by, the patient to provide a "return" path for the current of the electrode.

Both electrodes 30 and 32 extend from the hand piece 16 which contains a pair of internal insulated conductors 34 that are contact with the proximal end of the electrodes.

The first electrode 30 has a tip 36 which extends from a first spring member 38 that is cantilevered from the hand piece 16. The electrode 30 is preferably constructed from a phosphor-bronze or stainless steel, wire or tube, that is 0.2-1.5 mm in diameter. The spring portion 38 of the first electrode 30 is preferably 50 millimeters (mm) long. In one embodiment, the tip 36 has an included angle of between

15-60°, 30° nominal, and a nose radius of approximately 50  
microns. A majority of the electrode 30 is covered with an  
insulating material to prevent arcing, and to protect non-  
target tissue, the user and the patient. The relatively  
5 light spring force of the probe provides a sufficient  
electrode pressure without penetrating the cornea.

The second electrode 32 includes a disk portion 40  
which extends from a second spring member 42 that is also  
cantilevered from the hand piece 16. The disk portion 40  
10 is spaced a predetermined distance from first electrode 30  
and has an aperture 44 that is concentric with the tip 36.  
In the preferred embodiment, the disk portion 40 has an  
outer diameter of 5.5 mm and an aperture diameter of 3.0  
mm. The disk 40 further has a concave bottom surface 46  
15 that generally conforms to the shape of the cornea or  
sclera.

In one embodiment, the bottom surface 46 has a  
spherical radius of approximately 12.75 mm and a gripping  
surface to assist in the fixation of the eye. The second  
20 electrode 32 provides a return path for the current from  
the first electrode 30. To insure proper grounding of the

cornea, the surface area of the disk 40 is typically 20-500 times larger than the contact area of the tip 36. In the preferred embodiment, the second spring member 42 is constructed to have a spring constant that is less than one-half the stiffness of the first spring member 38, so that the second electrode 32 will have a greater deflection per unit force than the first electrode 30. As shown in Fig. 3, the tip 36 and disk 40 are typically located at angles  $a'$  and  $a''$  which may range between  $30^\circ$ - $180^\circ$ , with the preferred embodiment being  $45^\circ$ . As shown in Fig. 5, the probe 12 is pressed against the cornea to allow the second electrode 32 to deflect relative to the first electrode 30. The second electrode 32 is deflected until the tip 36 is in contact with the cornea.

For surgeons who prefer "two handed" procedures, the probe could be constructed as two pieces, one piece being the first electrode, and the other piece being the second electrode which also stabilizes the eye against corneal movement. Although the probe has been described and shown denaturing a cornea, it is to be understood that the probes and methods of the present invention can be used to

denature other tissues to correct for wrinkles,  
incontinence, etc. For example, the probe could be used to  
shrink a sphincter to correct for incontinence. The  
technique would be basically the same with small closely  
5 spaced dots forming a tightening line, belt or cylinder.

Figure 6 shows a pattern of denatured areas 50 that  
have been found to correct hyperopic conditions. A circle  
of 8 or 16 denatured areas 50 are created about the center  
of the cornea, outside the visual axis portion 52 of the  
10 eye. The visual axis has a nominal diameter of  
approximately 5 millimeters. It has been found that 16  
denatured areas provide the most corneal shrinkage and less  
post-op astigmatism effects from the procedure. The circle  
of denatured areas typically have a diameter between 6-8  
15 mm, with a preferred diameter of approximately 7 mm. If  
the first circle does not correct the eye deficiency, the  
same pattern may be repeated, or another pattern of 8  
denatured areas may be created within a circle having a  
diameter of approximately 6.0-6.5 mm either in line or  
20 overlapping. It has been found that overcorrected  
hyperopic conditions may be reversed up to 80% by applying

a steroid, such as cortisone, to the denatured areas within 4 days of post-op and continued for 2 weeks after the procedure. The procedure of the present invention can then be repeated after a 30 day waiting period.

5       The exact diameter of the pattern may vary from patient to patient, it being understood that the denatured spots should preferably be formed in the non-visionary portion 52 of the eye. Although a circular pattern is shown, it is to be understood that the denatured areas may be located in  
10 any location and in any pattern. In addition to correcting for hyperopia, the present invention may be used to correct astigmatic conditions. For correcting astigmatic conditions, the denatured areas are typically created at the end of the astigmatic flat axis. The present invention  
15 may also be used to correct radial keratotomy procedures that have overcorrected for a myopic condition.

      The probe and power settings have been found to create denatured areas that do not reach the Descemets membrane. It has been found that denatured areas of the Bowmans layer  
20 in the field of vision may disturb the patients field of vision, particularly at night. The present invention

leaves a scar that is almost imperceptible by slit lamp examination 6 months after the procedure. It has been found that the denatured areas generated by the present invention do not produce the star effect caused by the refraction of light through the slits created in a corrective procedure such as radial keratotomy.

Figure 7 shows an alternate embodiment of a probe 60 which has a plurality of first electrodes 62 coupled to a cage 64. The cage 64 includes a first ring 66 separated from a second ring 68 by a number of spacers 70. The cage 64 can be connected to a handle (not shown) which allows the surgeon to more easily utilize the probe 60.

The first electrodes 62 extend through apertures 72 in the rings 66 and 68. The electrodes 62 can move relative to the cage 64 in the directions indicated by the arrows. The probe 60 has a plurality springs 74 located between the rings and seated on washers 76 mounted to the electrodes 62. The springs 74 bias the electrodes 62 into the positions shown in Fig. 7. In the preferred embodiment, the probe 60 includes 8 electrodes arranged in a circular pattern having a 7.0 millimeter diameter.

In operation, the probe 60 is pressed onto the cornea so that the electrodes 62 move relative to the cage 64.

The spring constant of the springs 74 is relatively low so that there is a minimal counterforce on the tissue. A

5 current is supplied to the electrodes 62 through wires 78

attached thereto. The probe 60 is preferably used as a

uni-polar device, wherein the current flows through the

tissue and into a return electrode attached to or held by

the patient. Alternatively, the probe 60 may be bi-polar

10 wherein one or more of the electrodes 62 would provide

power and the other electrodes may provide a ground return

path. The probe 60 may be configured so that the diameter

of the electrode placement is adjustable. The electrode

placement can vary incrementally between 5.5, 6.0, 6.5,

15 7.0, 7.5, 8.0, and 8.5 millimeters.

Figure 8a and 8b show a preferred method of correcting

for hyperopic conditions using the electrode system of the

present invention. As shown in procedural block 100

refractive readings are initially taken of both eyes with,

20 and then without, cycloplasia. In procedure block 102, the

interocular pressure and cornea thickness at the center of

the eye are taken with a tonometer and pachymeter,  
respectively. If the interocular pressure is 20 mm Hg or  
greater, for I.O.P. reduction, 1 drop of a .5% solution  
marketed under the trademark "Betagan" is applied to the  
5 cornea twice a day for 2-3 months and then initial test are  
repeated. A topography reading of the eye is then taken to  
determine the shape of the cornea in procedural block 104.

Approximately 30 minutes before the application of the  
electrode, the patient is given a mild tranquilizer such as  
10 5 mg of valium, and the surgeon administers drops, such as  
the drops marketed under the trademark "Madracyl", to  
dilate the pupil and freeze accommodation, in block 106.

Immediately before the procedure, 2 drops of a topical  
cocaine commonly known as "Proparacaine" is administered to  
15 the eyes in block 108. In block 110 an in line microscope  
light is directed to the cornea for marking purposes. Then  
the lighting may be directed in a lateral direction across  
the cornea. Laterally lighting the eye has been found to  
provide good visualization without irritating or

20 photobleaching the retina.

In procedural block 112, the surgeon marks 8 or 16 spots on the cornea, wherein the pattern has a preferred diameter of approximately 7 mm. The surgeon sets the power and duration setting of the power unit to the proper setting. In block 114, the surgeon then places the tip at one of the spot markings and depresses the foot switch of the system, so that power is supplied to the probe and transferred into the cornea. This process is repeated at all of the spot markings. The epithelium of the denatured areas are then removed with a spatula in block 116. If a diopter correction of -2.5-3.5 d, or -4.0-6.0 d is required the tip is again placed in contact with the spots and power is applied to the cornea to generate a deeper thermal profile in the stroma. The procedure is then checked with an autorefractor.

The eyes are covered with a patch or dark glasses, and the patient is given medication, in block 118. The patient preferably takes an antibiotic such as a drug marketed under the trademark "Tobrex" every 2 hours for 48 hours, and then 3 times a day for 5 days. The patient also preferably takes an oral analgesic, such as a drug marketed

under the trademark "Dolac", 10 mg every 8 hours for 48 hours and a drug marketed under the trademark "Globaset" every 8 hours for 48 hours. If the patient has been overcorrected, the procedure can be reversed by waiting 3-4 days after the procedure and then administering to the eyes 1 drop of a steroid such as cortisone, 3 times a day for 1-2 weeks.

Figure 9 shows a pattern of denatured areas 130 combined with a pattern of incisions 132 that can correct myopic conditions. The incisions can be made with a knife or laser in accordance with conventional radial keratotomy procedures. The incisions are made from a 3.5 mm diameter to within 1 mm of the limbus at a depth of approximately 85% of the cornea. Denatured areas are then created between the incisions 132 using the procedure described above. The power unit is preferably set at 0.75 W of power and a time duration of 0.75 seconds. The slow heating of the cornea is important for minimizing regression, and as such 0.75 seconds has been found to be a preferable time duration to account for the patients fixation ability and the surgeons reaction time. The denatured areas pull the

incisions to assist in the reshaping of the cornea. This procedure has been found to be effective for diopter corrections up to +10.0 d. Penetrating the cornea only 85% instead of conventional keratotomy incisions of 95% reduces the risk of puncturing the Descemets membrane and the endothelium layer. This is to be distinguished from conventional radial keratotomy procedures which cannot typically correct for more than 3.5 diopters.

The denatured pattern shown in Fig. 6 has been shown to correct up to 7.0 diopters. As shown in Figure 10, a circumferential pattern of incisions 134 may be created in addition to a pattern of denatured areas 136, to increase the correction up to 10.0 diopters. The incisions will weaken the eye and allow a more pronounced reshaping of the eye. The pattern of incisions may be created at either a 6 mm diameter or a 8 mm diameter. The incisions typically penetrate no greater than 75% of the cornea. The contractive forces of the denatured areas may create gaps in the incisions. It may be preferable to fill the gaps with collagen or other suitable material.

Figure 11 shows an alternate embodiment of a probe which has a single electrode 140. The electrode 140 has a tip 142 which is preferably 0.009 inches in diameter. The tip extends from a spring beam 144 that is bent so that the surgeon can place the tip onto the cornea over nose and brow without impairing the surgeon's vision. The spring beam 144 is preferably insulated and is 0.2-1.5 mm in diameter. The spring beam 144 extends from a base 146 that is inserted into the hand piece. The base 146 is preferably constructed from stainless steel and is 0.030-0.125 inches in diameter, with a preferred diameter of 0.060-0.095 inches.

As shown in Figure 11a, the end of the tip 142 is preferably flat and has a textured surface 148. The textured surface 148 slightly grips the cornea so that the tip does not move away from the marking when power is applied to the eye.

As shown in Figure 12, the probe 200 has a return electrode lid speculum 202 that maintains the eye lid in an open position. The speculum 202 has a pair of cups 204 located at the end of wire 206. The cups 204 are placed

under an eye lid and maintain the position of the lid during the procedure. Extending from the lid speculum 202 is a wire 208 that is typically plugged into the unit 14 "return" connector. It has been found that the procedure of the present invention will produce more consistent results when the probe 200 uses the lid speculum 202 as the return electrode. The impedance path between the probe 200 and the lid speculum 202 is relatively consistent because of the relatively short distance between the lid speculum 202 and the probe 200, and the wet interface between the cornea and the lid speculum 202.

Figures 13-15 show alternate probe tip embodiments. The tips have steps that increase the current density at the corneal interface. The tips are preferably constructed from a stainless steel that is formed to the shapes shown. The tip 220 shown in Fig. 13 has a cylindrical step 222 that extends from a base 224. The step 222 terminates to a point, although it is to be understood that the end of the step 222 may have a flat surface. In the preferred embodiment, the base 224 has a diameter of 350 microns

(um), and the step 222 has a diameter of 190 microns and a length of 210 microns.

The tip 230 shown in Fig. 14, has a first step 232 extending from a base portion 234 and a second step 236 extending from the first step 232. The end of the second step 236 may be textured to improve the contact between the probe and the cornea. In the preferred embodiment, the first step 232 has a diameter of 263 microns and a length of 425 microns, the second step 236 has a diameter of 160 microns and a length of 150 microns . The tip 240 shown in Fig. 15, has a first step 242 that extends from a base portion 244 and a second tapered step 246 that extends from the first step 242. In the preferred embodiment, the first step 242 has a diameter of 290 microns and a length of 950 microns. The second step 246 has a diameter of 150 microns, a length of 94 microns and a radius of 70 microns.

Figures 16 and 17 show alternate probe tip embodiments which have an outer electrode concentric with an inner electrode. The electrodes are coupled to the unit so that the electrodes can provide current to the cornea either simultaneously or sequentially. By way of example, it may

be desirable to initially apply power to the cornea with the inner electrode and then apply power with the outer electrode, or apply power with both electrodes and then apply power with only the outer electrode. Assuming the same current value, the inner electrode will apply power with a greater current density than the outer electrode. The dual electrode probes allow the surgeon to create different thermal profiles, by varying the current densities, waveforms, etc. of the electrodes.

The probe 250 shown in Fig. 16 has an inner electrode 252 that is concentric with an intermediate layer of insulative material 254 and an outer conductive layer 256. In the preferred embodiment, the inner electrode 252 may have a diameter of 125 microns and extend from the outer layers a length of 150 microns. The outer layer 256 may have diameter of 350 microns. The inner electrode 252 may be capable of being retracted into the insulative layer 254 so that the inner electrode 252 is flush with the outer electrode 256, or may be adjusted between flush and full extension, either manually or under servo control.

Fig. 17 shows another alternate embodiment, wherein the probe 260 has an additional outer sleeve 262. The sleeve 262 has an internal passage 264 that supplies a fluid. The fluid may be a gas that stabilizes the current path to the cornea or a relatively high impedance solution (such as distilled water) which provides a coolant for the eye.

Figure 18 shows an economical detachable probe 270 embodiment. The probe tip 270 has a conductive wire 272 that is located within a plastic outer housing 274. The probe tip 270 has a flexible section 276 that extends from a body 278, preferably at a 45° angle. The tip 280 extends from the flexible section 276, preferably at a 90° angle. Extending from the opposite end of the handle 278 is a male connector 282. The connector 282 may have a conductive sleeve 284 that is inserted into the socket 286 of a female probe connector 288. The end of the wire 272 may be pressed between the inner surface of the sleeve 284 and the outer surface of the male connector 282 to provide an electrical interconnect between the tip end 280 and the female probe connector 288. The sleeve 284 may have a detent 290 to secure the probe tip 270 to the probe

connector 288. The probe tip end 280 may have distal shape configurations similar to the tips shown in Figs. 11, 13, 14, 15, 16, or 17.

Figure 19 shows a circuit 300 that will prevent the use of the probe tip beyond a predetermined useful life. The circuit 300 has a plurality of fuses 302 that are blown each time the probe is used for a procedure. The probe is rendered inoperative when all of the fuses 302 are blown. The circuit 200 typically has 10-30 fuses 302, so that the probe can only be used 10-30 times. The circuit 300 (not shown) is preferably located on a printed circuit board (not shown) mounted to the probe. The fuses 302 may be covered with a flash inhibitor such as silica sand to prevent fuse alloy splatter/spray when the fuses are blown.

In the preferred embodiment, the fuses 302 are connected to drivers 304 that are coupled to a plurality of serial to parallel shift registers 306. The clock pin (CLK) pins and input pin D of the first shift register are connected to the unit 14. The unit 14 initially provides an input to the first shift register and then shifts the input through the registers 306 by providing a series of

pulses on the clock pin CLK. An active output of a register 306 will enable the corresponding driver 304 and select the corresponding fuse 302. The unit 14 may clock the input through the shift registers 306 in accordance with an algorithm contained in hardware or software of the unit, wherein each clock signal corresponds to the end of a procedure. By way of example, a clock signal may be generated, and a fuse blown, upon the occurrence of four shots that have a power greater than 0.16 W and a duration greater than 0.25 seconds.

The circuit 300 may have a separate sample unit 308 that is coupled to the unit 14 and the fuses 302. The sample unit 308 may have an optical coupler 310 which isolates the unit 14 from power surges, etc. or may be any voltage or current threshold/comparator circuitry known in the art. The sample unit 308 may have a relay 312 that closes a switch when the fuses 302 are to be sampled. The sample circuit 308 samples the fuses 302 to determine how many fuses 302 are not blown. The number of remaining fuses 302, which correlate to the amount of procedures that can be performed with that particular probe, may be

provided by a display on the unit 14. By way of example,  
after sampling the fuses, the unit 14 may display the  
number 6 providing an indication that 6 more procedures can  
be performed with the probe. A 0 on the display may  
5 provide an indication that the probe must be replaced.

To sample the fuses 302, the unit 14 sets relay 312 to  
"sample" and clocks an input through the registers 306. If  
the fuse 302 is not blown when the corresponding driver 304  
is enabled by the output of the register, the optical  
10 coupler 310 will be enabled. If the fuse 302 is blown the  
optical coupler 310 will not be enabled. The process of  
enabling a driver 304 and monitoring the output of optical  
coupler 310 is repeated for each fuse 302. The unit 14  
counts the number of viable fuse links remaining to  
15 determine the remaining useful lives of the probe.

Figure 20 shows an alternate probe tip design 350. The  
probe tip 350 includes a spring beam 352 that extends from  
a handle 354. Also extending from the handle 354 is a male  
connector 356. The male connector 356 can be connected to  
20 the female connector of the probe shown in Fig. 18. The  
connector 356 allows the tip 350 to be replaced with a new

unit. The handle 354 preferably has an outer plastic shell 358 that can be grasped by the surgeon. The shell 358 is constructed from a dielectric material that insulates the surgeon from the current flowing through the probe. The  
5 spring beam 352 is also typically covered with an electrically insulating material. Attached to the spring beam 352 is a tip support member 360.

As shown in Figure 21, the tip support 360 has a tip 362 which extends from a stop 364. The tip 362 may be the  
10 point of a wire 366 that extends to the spring beam 352. The wire 366 may be strengthened by a thickened base portion 368. The thicker wire portion 368 can be either a stepped single wire or a wire inserted into a hollow tube. There may be multiple tip supports and tips 362 attached to  
15 a single spring beam 352.

As shown in Figure 22, during a procedure, the tip 362 is inserted into the cornea. The length of the tip 362 is typically 300-600 microns, preferably 400 microns, so that the electrode enters the stroma. The stop 364 limits the  
20 penetration of the tip 362. The diameter of the tip 362 is

preferably 125 microns. The tip diameter is small to minimize the invasion of the eye.

The power supply provides a current to the cornea through the tip 362. The current denatures the stroma to correct the shape of the cornea. Because the tip 362 is inserted into the stroma it has been found that a power no greater than 0.2 watts for a time duration no greater than 1.0 seconds will adequately denature the corneal tissue to provide optical correction of the eye. The frequency of the power is typically between 1-20 KHz and preferably 4 KHz. Inserting the tip 362 into the cornea provides improved repeatability over probes placed into contact with the surface of the cornea, by reducing the variances in the electrical characteristics of the epithelium and the outer surface of the cornea.

In the preferred embodiment, the spring beam 352 is 0.90 inches long with a diameter of 0.05 inches. The tip support may be 0.25 inches long. The tip 362 may have an embedded layer of dielectric material 370 that prevents current from flowing through the epithelium. The tip 362 may be constructed from a 302 stainless steel wire that is

subjected to a centerless grinding process. The grounded wire can then be exposed to a chemical milling process to create a sharp point.

Figure 23 shows an alternate embodiment of a tip 370 wherein the spring beam 372 has a plurality of notches 374 to decrease the stiffness of the beam 372. Figure 24 shows an alternate embodiment of an electrode 380 that has a coil spring 382 located between a tip 384 and a proximal end 386. Like the spring beams 352 and 372 the coil spring 382 allows the tip 384 to be displaced when the surgeon presses the electrode into the cornea to prevent over-insertion of the tip 384. Fig. 25 shows another embodiment of an electrode 390 with a folded flat spring 392 located between a tip 394 and a proximal end 396.

Figure 26 shows an embodiment of a power supply 400 that can provide power and determine the state of electrical contact between an electrode 402, a cornea 404 and a return element 406. The electrode 402 may be connected to an electrode pin 408 of the power supply 400. The return element 406 may be connected to a return pin 410 of the power supply 400.

The electrode pin 408 and the return pin 410 may be connected to a current to voltage converter 412. The converter 412 provides an analog output voltage to an analog to digital A/D converter 414. The analog output voltage of the voltage converter 412 is a function of a voltage drop between the electrode pin 408 and the return pin 410. The output voltage is also provided to a pulse counter 416.

The A/D converter 414 and pulse counter 416 may be connected to a controller 418. The A/D converter 414 may provide the controller 418 with a binary bit string that represents a value of the voltage from the converter 412. The A/D converter 414 may include a sample and hold circuit so that the converter 414 output corresponds to the peak voltage provided by the converter 412. The pulse counter 416 may provide a feedback signal to the controller 418 to provide an indication that energy was delivered to the cornea 404.

The controller 418 may be connected to a radio frequency (RF) pulse generator 420 and an output switch 422. The pulse generator 420 may be an L-C circuit that

produces a damped RF waveform in response to an impulse from the controller 418. The controller 418 may generate a series of impulses that produce a series of damped waveforms that are provided to the cornea 404. By way of example, each impulse may be a five volt, one nanosecond pulse provided to the pulse generator 420. The controller 418 may perform an automatic gain control function to increase or decrease the amplitude of the impulse provided to the pulse generator 420 as a function of the feedback signal. For example, the controller 418 may decrease the amplitude for a dry cornea and increase the amplitude for a wet cornea.

The output switch 422 may be switched between an on state and an off state. In the off state the output provides a safety feature, wherein power is not supplied to the cornea 404.

The controller 418 may be connected to a DC power supply 424 and a display 426. The display 426 may include a pair of indicator lights designated "wet" and "dry". The controller 412 may also be connected to a power adjustment circuit 428, a time adjustment circuit 430 and a switch

432. The switch 432 may be a footswitch or a handswitch that can be manipulated by the surgeon to initiate a routine of the controller 418. The adjustment circuits 428 and 430 allow the surgeon to vary the level and time  
5 duration of energy provided to the electrode 402, respectively.

The controller 418 may perform a software routine in accordance with an algorithm shown in Figure 27. Initially, the surgeon couples the return element 404 to  
10 the cornea and places the electrode 402 in contact with the cornea tissue. In step 500 the surgeon closes the switch 432 which provides an input to the controller 418. The controller 418 will then enter a test routine. In the test routine the controller 418 provides a series of impulses to  
15 the pulse generator 420 to generate a series of RF pulses in step 502. The controller 412 also switches the switch 422 to an "on" state so that the pulses are transmitted to the cornea 404 through the electrode 402.

The amount of pulses provided during the test routine  
20 is typically a fraction of the pulses provided during normal operation. For example, if the power supply

normally provides 4800 pulses per 0.6 seconds to denature  
the cornea, the supply 400 may provide 100 pulses during  
the test routine. The lower amount of total energy allows  
the power supply to test the electrical contact without  
5 providing enough energy to significantly effect the cornea.

The RF pulses return to the voltage converter 412  
through the return element 406 and return pin 410. A value  
that is a function of the voltage at the return pin 410 is  
provided to the controller 418 through the voltage 412 and  
10 A/D 414 converters in step 504.

The controller 418 may differentiate the voltage value  
provided by the A/D converter 414 to obtain the time rate  
of change of the voltage and corresponding resistance in  
step 506. The differentiated voltage may be used because  
15 the tissue will undergo a slight change in resistance in  
response to the energy provided by the power supply.

Although a differentiated voltage is described, it is to be  
understood that the controller 418 can utilize some other  
voltage characteristic such as an undifferentiated voltage  
20 amplitude. The controller 418 may then compare the actual  
differentiated voltage value with an upper threshold.

If the differentiated voltage value is equal to or greater than the upper threshold the controller 420 may generate a dry indicator output signal to activate the dry indicator. In step 510, the activated dry indicator  
5 provides an indication that the cornea is too dry. The controller 418 can also switch the switch 422 to the off state.

If the actual value is below the upper value the controller 418 can compare the actual value to a lower  
10 threshold in step 512. If the actual value is less than or equal to the lower threshold then the controller may generate a wet indicator output signal that activates the wet indicator and turn off the switch 422 in step 514. If the actual differentiated value is not less than the  
15 threshold range, the test routine will terminate and the controller 418 may continue to allow pulses to be provided to the cornea in step 516. The pulses are provided for a time period that will denature the cornea.

It may be desirable to prevent the tip from rotating  
20 relative to the handle to prevent any tearing of the cornea. Figures 28a-j show alternate embodiments of a

proximal end of an electrode 500 that has an anti-rotation feature. The electrode 500 can be inserted into an opening 502 of a handle 504. Fig. 28a shows an opening 502 with a key 506 that fits within a corresponding slot 508 of the electrode 500. The key 506 and slot 508 configuration prevent rotation of the electrode 500 relative to the handle 504. Alternatively, the electrode 500 may have the key 506 and the handle 504 may have the slot 508. Fig. 28b shows another key type configuration wherein the handle 504 and electrode 500 have matching flat surfaces 510.

Figures 28c-h show a handle 504 with a circular opening 502 and an electrode 500 which has a dissimilar proximal end shape. Fig. 28c shows a square shaped proximal end, Fig. 28d shows a triangular shape, Fig. 28e depicts a ellipsoidal shape, and Fig. 28f shows a hexagonal shape. Fig. 28g shows an electrode proximal end that has a plurality of cam surfaces that prevent relative rotation between the electrode 500 and the handle 504. Fig. 28h shows an electrode 500 that has a spline 512.

Fig. 28i shows an electrode 500 that has a pair of beams 514 that can be inserted into a pair of corresponding

openings 516 in a handle 504. Alternatively, the handle 504 may have beams 514 and the electrode 500 may have the openings 516. Fig. 28j shows an embodiment wherein the proximal end of the electrode 500 and the opening of the handle 504 both have a rectangular shape.

Figure 29 shows an alternate embodiment of a probe tip assembly 550. The probe tip assembly 550 includes an arm 552 that holds a probe 554. The probe 554 may include an electrode 556 that extends through a probe body 558. A proximal end 560 of probe tip assembly arm 552 may be connected to a power supply (not shown). The proximal end of the electrode 556 may be connected to an apparatus that can pull on the electrode 556 until the tip is exposed a desired length. Then the electrode 556 can be attached to the probe body by crimping, soldering or other means. A distal end 562 of the electrode 556 may have a tip end that is adapted to be placed in contact with a cornea. The handle 558 may be constructed from a metal material that is partially coated with a dielectric material such as paralene that prevents an electrical path to the top

surface of the cornea. The probe body 558 can be crimped or otherwise electrically connected to the electrode 556.

The probe body 558 may include an outer groove 564 that is adapted to receive a detent ball 566. The ball 566 may be biased into the groove 564 by a spring 568. The ball 566 may be located within a sleeve portion 570 of the arm 552. The probe body 558 may extend through an inner channel 572 of the sleeve 570.

The probe 554 can be replaced by pulling the probe body 558 out of the inner channel 572. The inner groove 564 may have a tapered surface such that the detent ball 566 is pushed out of the groove 564 when the handle 558 is pulled out of the sleeve 570. A new probe 554 can be inserted into the channel 572. The probe body 558 may have a stop 574 that limits the insertion depth of the probe 554.

Figure 30 shows a probe holder 590 that provides a protective insertion package for the probe 554 shown in Fig. 29. The holder 590 may include a sleeve 598 that has an inner channel 594 adapted to receive the probe 554. The sleeve 598 may be constructed from a plastic material such as ABS or polyurethane. The channel 594 may include ribs 596

that grip the probe. The holder 590 may also have a knurled outer layer 598 that allows the operator to more readily grasp the sleeve 592 and push the probe into the arm sleeve shown in Fig. 29.

5 Figure 31 shows an alternate embodiment of a probe assembly 600. The assembly 600 includes a probe 602 that is connected to an arm 604. The probe 602 may include a female socket 606 that receives a male pin 608 of the arm 604. The socket 606 may include a dimple portion 610 that  
10 exerts a pressure to secure the probe 602 to the pin 608.

Figure 32 shows an embodiment of the probe 602. The probe 602 may include an electrode 612 that extends through an inner channel 614 of a plastic sleeve 616. The  
15 electrode 612 may be connected to a hollow metal rivet 618 that is coupled to the female socket 606 shown in Fig. 31. The electrode 612 can be secured to the sleeve 616 with an adhesive 620. The adhesive 620 can be cured with ultraviolet light. A tip portion 622 of the electrode 612 may extend from the end of the sleeve 612.

20 Figure 33 shows an alternate embodiment of the probe assembly 600' wherein an electrode 612' is wrapped through

holes 624 in the sleeve 616' to create a "thread" within the probe 602'. The electrode 612' can be routed through the holes 624 after the wire is secured to the sleeve 612' by an adhesive 620.

5 The pin 608' may have a corresponding groove 626 that can receive the threaded electrode 612'. This embodiment provides a probe that has a dielectric outer sleeve 616' with an internal contact thread that provides an electrical path between the electrode tip and the male pin 608'. The dielectric outer sleeve 616' provides a protective element for the probe.

10 Figure 34 shows an embodiment of a handle 630 for a probe 632. The handle 630 may be connected to an electrode 634. The handle 630 may be constructed from a molded and/or machined plastic material and have a textured outer surface 636. The handle 630 may have a size and shape that allows a surgeon to hold the probe 632 with three fingers.

15 Figure 35 shows an embodiment of a system 700 that can denature a cornea 702. The system 700 may include an energy device 704 that can direct energy to a focal point 706 located within a stroma layer 708 of the cornea 702.

The energy shall be sufficient to denature the corneal tissue within the stroma 708. By way of example, the energy device may be a coherent light source such as a laser, or a non-coherent light source such as a Xeon flash lamp. The light source shall provide light at an intensity and wavelength that will denature the tissue within the stroma 708.

The focal point 706 of the energy may be moved within the stroma layer 708 by a movement device 710. The movement device 710 may include a lens 712 to focus the energy from the energy device 704, and a mechanism 714 to move the lens 712. The movement device 710 may further have a controller 716 to control the mechanism 714 and a feedback sensor 718 that is coupled to the lens 712, the mechanism 714 and the controller 716. By way of example, the mechanism 714 may include a rack and pinion gear assembly that is driven by a rotary motor. The mechanism 714 may include a voice coil motor, a solenoid, or a stepper motor to drive the movement of the lens 712. Alternatively, the mechanism 714 may include a shaped

memory metal such as NITINOL that is heated to move the lens 712.

The controller 716 can provide output signals to the mechanism 714 to incrementally move the lens 712 and the focal point 706 of the energy. The feedback sensor 718 can provide input signals to the controller 716 to provide a closed loop feedback on the position of the mechanism 714 and the lens 712. By way of example, the feedback sensor 718 may be an optical encoder, magnetic encoder, linear variable differential transformer, Hall effect sensor, linear resistor sensor, or proximity sensor.

An alternate embodiment may include a very fine hypodermic tube with an optical fiber therein, and a mechanism to move the tubing and fiber in incremental steps.

As shown in Figure 36, by moving the focal point of the energy emitted from the device 704, the system 700 can create a volume of denatured corneal tissue 720 that has an essentially uniform cross-sectional area through at least a portion of the stroma 708. A plurality of denatured columns may be created throughout the cornea 702 to modify

visual activity. The column of denatured tissue 720 will result in less regression of the modified visual acuity than a cornea modified with conical shaped denatured areas typically created with systems that do not move the focal point 706.

Figure 37 shows an alternate embodiment wherein the energy device includes an ultrasonic transducer(s) 750 that is excited by one or more ultrasonic driver(s) 752. The ultrasonic transducer 750 may include one or more piezoelectric transducers (not shown) as is known in the art. The shaped transducer or transducer array 750 may direct energy to a focal point 754. The transducer assembly 750 and corresponding focal point 754 may be moved by a movement device 756. The movement device 756 may include a mechanism 758 to move the transducer assembly 750. The movement device 756 may further have a controller 760 to control the mechanism 758 and a feedback sensor 762 that is coupled to the transducer assembly 750, the mechanism 758 and the controller 760. By way of example, the mechanism 758 may include a rack and pinion gear assembly that is driven by a rotary motor. The mechanism

758 may include a voice coil motor, a solenoid, or a stepper motor to drive the movement of the transducer assembly 750. The mechanism 758 may include a shaped memory metal such as NITINOL that is heated to move the  
5 transducer assembly 750.

The controller 760 can provide output signals to the mechanism 758 to incrementally move the transducer assembly 750 and the focal point 754 of the energy. The feedback sensor 762 can provide input signals to the controller 760  
10 to provide a closed loop feedback on the position of the mechanism 756 and transducer assembly 750. By way of example, the feedback sensor 762 may be an optical encoder, magnetic encoder, linear variable differential transformer, Hall effect sensor, linear resistor sensor, or proximity  
15 sensor, or other precision feedback sensors known in the art.

Figure 38 shows another embodiment wherein light is directed onto the cornea 702 from a plurality of optical fibers 780a-d. The optical fibers 780a-d may be coupled to  
20 a light source 782 such as a laser. Each fiber 780a-d may direct the light to a different focal point 784a-d. Each

fiber 780a-d may have a shutter 786a-d that can be opened and closed such that only one fiber directs light onto the cornea 704 at any given time. The shutters 786a-d may be controlled by a controller 788. The focal point of light energy can be varied by sequentially opening and closing the shutters 786a-d of each fiber 780a-d. Alternatively, or in addition to, each fiber 780a-d may have separate light sources that are sequentially energized to vary the focal point of light directed to the cornea 702.

An alternate embodiment may include a contact laser/light source with a diamond distal end to heat sink the cornea tissue. A single lens element may be moved proximal to the diamond end to change the focal point.

Figure 39 shows an alternate embodiment of a system that includes a plurality of energy devices 800 attached to a substrate 802. The energy devices 800 may be arranged in a planar or phased array. The energy devices 800 may be controlled by a controller 804. Each energy device 800, or combination of energy devices may deliver energy to a different focal point 806 within the cornea 702. The controller 804 may sequentially select one or more energy

devices 802 to vary the focal point of energy directed to the cornea 704. The energy devices 802 may emit energy at ultrasonic, radio or microwave frequencies, or a combination thereof.

5           Figure 40 shows another embodiment of a system 820 that includes a plurality of needles or sharps 820. The needles 820 can be inserted into the stroma layer 708 of the cornea 702. The needles 820 may be supported by a ring 822 that is placed on the cornea 702. The ring 822 allows for the  
10 simultaneous creation of multiple denatured volumes. The needles 820 may be heated by an inductive heating coil 824. The heating coil 824 can provide energy to the heated needles 820 wirelessly through electromagnetic induction between the coil 824 and needles 820. The inductive signal  
15 may have a frequency range between 50-500KHz. Heat from the needles 820 is transferred into the cornea 702 to create a column of denatured tissue within the stroma 708.

          An alternate embodiment may include optical fibers coupled to a laser source. Each optical fiber may be  
20 translucent along the length of the fiber to create the column of denatured tissue. The translucence of the

optical fiber may vary in graduated steps along the length  
of the fiber.

While certain exemplary embodiments have been described  
and shown in the accompanying drawings, it is to be

5 understood that such embodiments are merely illustrative of  
and not restrictive on the broad invention, and that this  
invention not be limited to the specific constructions and  
arrangements shown and described, since various other  
modifications may occur to those ordinarily skilled in the  
10 art.